STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445391	A. BUILDING _____ B. WING _____	12/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANCHESTER HEALTH CARE CENTER	395 INTERSTATE DRIVE MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The annual Recertification Survey was completed on December 10 - 13, 2012.	F 000	This Plan of Correction has been developed in compliance with State and Federal Regulations. This plan affirms Manchester Health Care Center's intent and allegation of compliance with those regulations. This	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to maintain visual privacy during patient care for one resident #4, of thirty six sampled residents. The findings included: Observation on December 11, 2012, at 8:48 a.m., in the resident's room, during morning medication administration, revealed Licensed Practical Nurse (LPN) #1 exposed resident #4's shoulders and upper chest while changing a transdermal (by skin) Lidoderm (a non- narcotic medication used to treat pain) patch on the resident's left shoulder. Observation revealed the LPN then checked placement of a transdermal Durgesic (a narcotic medication also used for pain) on the resident's right shoulder. Observation revealed the resident's roommate had full line of sight when the nurse exposed the resident's upper chest . Interview with LPN #1 on December 11, 2012, at 8:50 a.m., in the hallway outside the resident's room, confirmed the failure to maintain full visual	F 241	POC does not constitute an admission or concession of either accuracy or factual allegation made in, or existence or scope of significance, of any cited deficiency. F 241 1.LPN # 1 was in-serviced on 12/14/12 by the Director of Nursing on maintaining privacy during patient care. Resident # 4 was assessed by the Director of Nursing on 12/14/12. No adverse outcomes were noted. 2. The Director of Nursing and Assistant Director of Nursing began observation of rounds of nursing staff to ensure privacy is provided during administration of patches and care given on 12/14/12. 3. The Director of Nursing and Assistant Director of Nursing on 12/14/12-1/2/13 began in-servicing licensed nursing staff on providing privacy during medication administration or care. 4. The Director of Nursing and Assistant Director of Nursing will audit two licensed staff daily while administering medications or providing care to insure privacy. Rounds will be made daily starting 1/2/13: five (5) days per week for four (4) weeks; then three (3) days per week for four (4) weeks; then one (1) time per week for four (4) weeks and/or 100% compliance. The audit will be reported by the Director of Nursing monthly to Quality Assurance Performance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Ted K. Terry — ADMINISTRATOR — 12-27-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 privacy for the resident during care.	F 241	Improvement Committee comprising of Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Nurse Educator, Activities Director, Minimum Data Set coordinator, Plant Operations Manager, Registered Dietitian, Directory of Dietary, Director of Therapy, and Medical Records Coordinator. Completion date: 1/2/13	1-2-13
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and interviews the facility failed to conduct a comprehensive assessment, following a significant physical change, of one (#94) of thirty-six residents reviewed. The findings included: Medical record review revealed Resident #94 was admitted to the facility on March 19, 2012, from an acute care hospital with diagnoses which included: Fracture Neck of Femure, Status Post Hip Surgery, Transient Ischemic Attack, Hypertension, Osteoarthritis, Depressive Disorder, Dyspepsia, and Gastroesophageal Reflux Disease.	F 274	**F 274** 1. Resident #94 was assessed by the Director of Nursing on 12/13/12. Resident was no longer in this facility as of 12/21/12. Director of Nursing inserviced Minimum Data Set coordinator on completing a comprehensive assessment when a resident has a significant change on 12/14/12. 2.A 100% audit of all medical records for current residents on 12/24/12 – 1/2/13 to assess need for comprehensive assessment was conducted by the Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Manager and Minimum Data Set coordinator . 3. The Director of Nursing inserviced the Minimum Data Set coordinator on completing a comprehensive assessment when a resident has a significant change on 12/14/12. 4.The Director of Nursing and Assistant Director of Nursing will assess 5 residents per day for significant change in status for five (5) days per week for four (4) weeks: then three (3) days per week for four (4) weeks; then one (1) day per week for four	

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F 274	Continued From page 2 Further review of the medical record revealed Resident #94 weighed 151 lbs on April 3, 2012, and weighed 141 lbs on May 1, 2012, for a 6.6 % weight loss in one month. Review of the resident's skin assessments, dated May 14, 2012, revealed "Open lesion to coccyx area". Review of the Minimum Data Set Assessment (MDS) revealed no comprehensive assessment had been performed within fourteen days following the resident's weight loss, or development of a pressure area. Interview with the Director of Nurses (DON) and the Assistant Director of Nurses (ADON), in the DON's office on December 13, 2012, at 12:25 p.m. confirmed a significant change MDS had not been completed following the resident's changes related to weight loss on May 1, 2012, and the resident development of a pressure area on May 14, 2012.	F 274	(4) weeks and/or 100% compliance. The results will be reported by the Director of Nursing monthly to Quality Assurance Performance Improvement Committee comprising of Administrator, Director of Nursing, Medical Director, Nurse Educator, Activities Director, and Minimum Data Set coordinator, Director of Social Services, Plant Operations Manager, Registered Dietitian, Director of Dietary, Director of Therapy and Medical Records Coordinator. Completion date 1/2/13	1-2-13
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		

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F 279	Continued From page 3 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interviews the facility failed to revise the comprehensive plan of care for one (#94) of thirty-six residents reviewed. The findings included: Medical record review revealed Resident #94 was admitted to the facility on March 19, 2012, from an acute care hospital with diagnoses which included: Fracture Neck of Femure, Status Post Hip Surgery, Transient Ischemic Attack, Hypertension, Osteoarthritis, Depressive Disorder, Dyspepsia, and Gastroesophageal Reflux Disease. Review of skin assessments, dated May 14, 2012, revealed "Open lesion to coccyx area". Review of wound assessment notes, dated May 15, 2012, revealed, "Left lower buttock...right lower buttock...right mid buttock...left mid buttock...unstagable deep tissue...wound edges irregular, reddened, deep purple...width 9 cm	F 279	**F 279** 1. Resident #94 was assessed by the Director of Nursing on 12/13/12. Resident was no longer in this facility as of 12/21/12. The Director of Nursing inserviced the Minimum Data Set coordinator to update care plan to reflect resident's current status on 12/14/12. 2. A100% audit of all care plans on 12/24/12 – 1/2/13 was conducted to insure current plan of care reflects resident's status by the Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Manager and the Minimum Data Set coordinator. 3. The Director of Nursing inserviced the Minimum Data Set coordinator to insure current plan of care reflects resident's status on 12/14/12. 4. The Director of Nursing and Assistant Director of Nursing will audit 5 care plans per day to insure current plan of care for five (5) days per week for four (4) weeks: then three (3) days per week for four (4) weeks; then one (1) day per week for four (4) weeks and/or 100% compliance. The results will be reported by the Director of Nursing monthly to the Quality Assurance Performance Improvement Committee comprising of Administrator, Director of Nursing, Medical Director, Nurse Educator, Activities Director, and Minimum Data Set coordinator, Director of Social Services, Plant Operations Manager, Registered Dietitian, Director of Dietary, Director of Therapy and Medical Records Coordinator. Completion date: 1/2/13	1-2-13

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F 279	Continued From page 4 (centimeters)...length 12 cm". The wound assessment note also stated, "Physician notified orders recieved, air mattress placed on bed, gel cushion remains in wheelchair, turn every 2 hours..." Review of the care plan, revealed the resident was identified with "Potential for Impaired Skin Integrity" on March 28, 2012 and interventions to prevent skin breakdown were planned on March 28, 2012. Further review of the care plan revealed no update or new interventions. Interview with the Director of Nurses (DON) and the Assistant Director of Nurses (ADON), on December 13, 2012, at 10:00 a.m., in the DON's office, confirmed Resident #94's care plan had not been updated before September 12, 2012	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280		

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F 280	Continued From page 5 each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to accurately update the resident care plan to reflect weight loss, for one resident, # 90 of thirty-six sampled residents. The findings included: Resident #90 was admitted September, 28, 2011, with diagnoses including Altered Mental Status, Gastroesophageal Reflux, Irritable Bowel Syndrome, Osteoarthritis, Generalized Anxiety Disorder, and Depression. Medical record review revealed the resident's weight on December 2, 2012, was 138 pounds. (16 pounds less than the weight six months prior or 11.6 percent weight loss) Weight on November 1, 2012, was 139 pounds. Weight on September 13, 2012, was 142 pounds, weight on June 4, 2012, was 154 pounds. Medical record review of the Dietary Progress Notes dated September 26, 2012, revealed the resident was placed on weekly weights, and supplements added to the diet. Continued review of the dietary progress notes revealed no additional entries in the notes until November 8, 2012. Review of the medical record revealed the resident was weighed weekly on September 26,	F 280	F 280 1. Resident #90 was assessed by the Director of Nursing on 12/13/12 Physician was notified by Director of Nursing on 12/13/12. Note new order. Director of Nursing inserviced Minimum Data Set coordinator to update care plan to reflect resident's current status on 12/14/12. 2. A100% audit of all care plans on 12/24/12 – 1/2/13 was conducted to insure current plan of care reflects resident's status by the Director of Nursing, the Assistant Director of Nursing, Social Services Director, Dietary Manager and the Minimum Data Set coordinator. 3. The Director of Nursing inserviced the Minimum Data Set coordinator to insure current plan of care reflects resident's status on 12/14/12. 4. The Director of Nursing and Assistant Director of Nursing will audit 5 care plans per day to insure current plan of care for five (5) days per week for four (4) weeks: then three (3) days per week for four (4) weeks; then one (1) day per week for four (4) weeks and/or 100% compliance The results will be reported by the Director of Nursing monthly to the Quality Assurance Performance Improvement Committee comprising of Administrator, Director of Nursing, Medical Director, Nurse Educator, Activities Director, and Minimum Data Set coordinator, Director of Social Services, Plant Operations Manager, Registered Dietitian, Director of Dietary, Director of Therapy and Medical Records Coordinator Completion date: 1/2/13	1-2-13

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F 280	Continued From page 6 2012, and again on October 1, 2012, and the resident weighed 144 pounds. Continued review of the medical record revealed the weekly weights were not performed as ordered after October 1, 2012, and the resident continued to lose weight. Review of the medical record revealed the resident's weight on November 1, 2012 was 139 pounds. Continued review revealed the facility did not perform weekly weights and the next weight on December 2, 2012 was 138 pounds. Review of the resident Care Plan dated November 9, 2012, revealed "...Problem...Nutrition...Potential for unintended weight gain..." Continued review of the medical record revealed the resident was not on a medically prescribed weight loss program. Interview with the dietary manager on December 12, 2012, at 3:20 p.m., in the dietary manager's office, confirmed the residents weekly weights were not performed as ordered after October 1, 2012, and the facility failed to update the residents care plan to accurately document and address weight loss for the resident.	F 280		
F 364 SS=C	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced	F 364		

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F 364	Continued From page 7 by: Based on medical record review, interview and observation, the facility failed to serve palliative vegetables for seven (#12, #73, #76, #88, #122, #141, and #171) residents of twenty residents interviewed. The findings included: Medical record review of the most recent Minimum Data Set Assessment for residents #12, #73, #76, #88, #122, #141, and #171 revealed all were oriented to year, month, date and were determined to be interviewable by the facility according to the Brief Interview for Mental Status (BIMS). Interviews conducted on December 10 and 11, 2012 with residents #12, #73, #76, #88, #122, #141, and #171 revealed each resident was asked scripted questions including, "Does the food taste good and look appetizing?" Each of the resident answered, "No" to the question. Observation and interview with the Administrator and the Director of Nursing (DON), on December 12, 2012, at 12:00 p.m., in the main dining room, included a sampling of the food served for the noon meal to the residents. The Administrator and the DON sampled the oriental vegetables , green beans, and macaroni and cheese. Interview with the Director of Nursing and the Administrator following sampling the food revealed the vegetables were, "Tastless" and "Mushy in texture." Further interview revealed the macaroni and cheese was "Starchy in texture with moderate taste".	F 364	F364 1. Resident #12 was interviewed by the Dietary Manager on 12/26/12 regarding taste, and appearance of vegetables. Resident #73 was interviewed by the Dietary Manager on 12/26/12 regarding taste, and appearance of vegetables. Resident #76 was interviewed by the Dietary Manager on 12/26/12 regarding taste, and appearance of vegetables. Resident #88 was interviewed by the Dietary Manager on 12/26/12 regarding taste, and appearance of vegetables. Resident #122 was interviewed by the Dietary Manager on 12/26/12 regarding taste, and appearance of vegetables. Resident #141 was interviewed by the Dietary Manager on 12/26/12 regarding taste, and appearance of vegetables. Resident #171 was interviewed by the Dietary Manager on 12/26/12 regarding taste, and appearance of vegetables. Registered Dietitian inserviced Dietary Manager regarding consistently using recipe book at each meal by each cook, to provide palliative, tasteful and nutritional meals on 12/12/12. 2. The Administrator or Dietary Manager began observation at the next meal on 12/12/12 for appearance of the vegetables and solicited feedback from the residents. 3. Registered Dietitian inserviced Dietary Manager regarding consistently using recipe book at each meal by each cook, to provide palliative, tasteful and nutritional meals on 12/12/12. Dietary Manager	

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F 364	Continued From page 8 Interview with the Administrator and DON in the dining room on December 12, 2012, at 12:08 p.m., confirmed the facility failed to serve palliative vegetables to the residents.	F 364	and/or Registered Dietitian will inservice the cooks on the consistent use of cookbooks, recipes, and appearance of the vegetables from 12/12/12 through 1/2/13. 4. Dietary Manager or Assistant Dietary	
F 371 SS=C	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of Material Safety Data Sheets and interview, the facility failed to store food in a sanitary manner. The findings included: Observations of the kitchen food preparation area, on December 10, 2012 at 8:55 a.m., revealed an open bucket containing "Oasis 146" cleaning solution, stored next to food under the food preparation table. Review of the Material Safety Data Sheet (MSDS) revealed Oasis 146 is a fluid sanitizer solution and is an eye irritant. Interview with the Dietary Manager (DM), in the kitchen, on December 10, 2012, at 9:00 a.m.., confirmed the open bucket contained Oasis 146 and was setting next to a 5 gallon container of	F 371	Manager will visit 5 residents daily specifically to assess the taste and quality of the vegetables.for five (5) days per week for four (4) weeks: then three (3) days per week for four (4) weeks; then one (1) day per week for four (4) weeks and/or 100% compliance The results will be reported by the Director of Nursing monthly to Quality Assurance Performance Improvement Committee comprising of Administrator, Director of Nursing, Medical Director, Nurse Educator, Activities Director, and Minimum Data Set coordinator, Director of Social Services, Plant Operations Manager, Registered Dietitian, Director of Dietary, Director of Therapy and Medical Records Coordinator Completion date: 1/2/13 **F371** 1.The sanitizer bucket was immediately removed by the Dietary Manager from the cook's table and stored in a suitable location with other chemical products on 12/10/12 away from food. The Administrator inserviced the Dietary Manager that the sanitizer bucket cannot be stored in the vicinity of food items on 12/10/12. 2. A 100% audit of the kitchen was completed by the Dietary Manager on 12/10/12 to insure that chemicals are stored	1-2-13

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F 371	Continued From page 9 cooking oil, one gallon container of teriyaki sauce, other assorted cooking sauces, and multiple boxes of open gloves. The dietary manager further stated "I know it's not supposed to be there, but we always keep it there." Further interview with the dietary manager on December 10, 2012, at 9:15 a.m., in the dietary department, confirmed cleaning solutions were not to be stored next to food.	F 371	appropriately away from food items. 3. Dietary staff was inserviced that the sanitizer bucket cannot be stored near food items by the Dietary Manager from 12/10/12 through 1/2/13. 4. The Dietary Manager or Assistant Dietary Manager will audit daily proper storage of chemicals in the kitchen.for five (5) days per week for four (4) weeks: then three (3) days per week for four (4) weeks; then one (1) day per week for four (4) weeks and/or 100% compliance. The results will be reported by the Director of Nursing monthly to Quality Assurance Performance Improvement Committee comprising of Administrator, Director of Nursing, Medical Director, Nurse Educator, Activities Director, and Minimum Data Set coordinator, Director of Social Services, Plant Operations Manager, Registered Dietitian, Director of Dietary, Director of Therapy and Medical Records Coordinator Completion date: 1/2/13	1-2-13
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		

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F 441	Continued From page 10 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to maintain contact isolation precautions for one resident, #176, of thirty- six residents reviewed. The findings included: Resident #176 was admitted to the facility on December 4, 2012, with diagnosis including Clostridium Difficile Diarrhea, (a contagious gastrointestinal bacterial illness spread by contact) and was placed on contact isolation for treatment. Observation on December 11, 2012, from 3:10 p.m. to 3:28 p.m., in the hallway outside the resident's room, revealed the resident to be on contact isolation which included the use of staff personal protective equipment, and disposable care equipment for the resident, contained in an isolation kit attached to the resident's room door. Continued observation revealed a sign attached to the resident's door advising visitors to report to	F 441	F 441 1. The staff member was in-serviced on 12/11/12 on contact precautions by the Director of Nursing. The laptop was placed in red biohazard bags and sealed to prevent cross contamination immediately on 12/11/12. 2. The Director of Nursing and Assistant Director of Nursing began in-servicing and observation of Nursing staff, Therapy staff, Housekeeping staff, Dietary staff, Administrative staff, Activities staff, and maintenance staff on 12/11/12 thru 1/2/13 to validate compliance with contact isolation precautions. 3. The Director of Nursing and Assistant Director of Nursing began in-servicing and observation of Nursing staff, Therapy staff, Housekeeping staff, Dietary staff, Administrative staff, Activities staff, and maintenance staff on 12/11/12 thru 1/2/13 about contact isolation. 4. The Director of Nursing and Assistant Director of Nursing will observe staff for following contact isolation precautions 3 times per day for five (5) days per week for four (4) weeks: then three (3) days per week for four (4) weeks; then one (1) day per week for four (4) weeks and/or 100% compliance. The results will be reported by the Director of Nursing monthly to Quality Assurance Performance Improvement Committee comprising of Administrator, Director of Nursing, Medical Director, Nurse Educator, Activities Director, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445391	A. BUILDING _____ B. WING _____	12/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 11 the nursing station prior to entering the room. Continued observation revealed a staff member dressed in a paper isolation gown, disposable latex gloves, and paper shoe covers, seated at the resident's beside, typing on a laptop computer with gloved hands. The laptop computer was resting in the staff member's lap, which was covered by the isolation gown. Continued observation revealed the staff member placed the computer on the resident's bedside table, conducted care and made contact with the resident, and then typed on the laptop with gloved hands. Review of the facility policy "Contact Precautions" revealed, "...dedicated resident care equipment should be considered..." Interview with the Assistant Director of Nursing on December 4, 2012, at 3:31 p.m., in the hallway outside the resident's room, confirmed the facility's isolation policy did not permit the use of mobile computer equipment in isolation rooms. Continued interview confirmed the staff member observed was not to have taken the laptop computer into the isolation room or entered data into the computer with gloved hands while inside the resident's room.	F 441	Minimum Data Set coordinator, Director of Social Services, Plant Operations Manager, Registered Dietitian, Director of Dietary, Director of Therapy and Medical Records Coordinator. Completion date: 1/2/13	1-2-13